LOS ANGELES COUNTY - DEPARTMENT OF HEALTH SERVICES
ALCOHOL AND DRUG PROGRAM ADMINISTRATION

STAFF HOURS

PROPOSITION 36 USE ONLY

PROVIDER NAME:_____ CONTRACT NO.:

ADDRESS:_____ CLAIM PERIOD:

CITY:_____ DATE PREPARED:

SERVICE CATEGORY:_____ PROVIDER NO.:

CONTACT PERSON:_____

ORIGINAL ( ) SUPPLEMENTAL ( )

SECTION I - PROVIDER SERVICE DETAIL

	Staff Member's Name	Budgeted Position	Total Staff Hours
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13	TOTAL		

(If more than one sheet is used, detach on heavy line, except last sheet of claim).

SECTION II - GROSS AMOUNT REQUESTED

14	Total Staff Hours	
15	Fee-For-Service Rate	$
16	Staff Hours Times Rate	$

SECTION III - REVENUE

17	Grants	$
18	Clients Fees	$
19	Insurance	$
20	Other	$
21	Total Revenue	$

SECTION IV - NET AMOUNT REQUESTED

(NOT TO BE COMPLETED FOR NET PROGRAM CONTRACTS)

22	Gross Amount Requested (Line 16)	$
23	Total Revenue (Line 21)	$
24	NET AMOUNT (22 LESS 23)	$

COUNTY USE ONLY

Amount Requested: $

Carry Forward Amt.: $

Total Amt. Payable: $

By_____ Date_____

LIMITED MONTHLY ALLOCATION
Total Amount
Payable: $_____

By_____Date_____

Payment on this claim may be delayed or withheld if this request for reimbursement contains errors or omissions.

AUTHORIZED SIGNATURE DATE